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Background Information: Children

I. General Information

Date_____

All Parent/Guardian Names:		
Street Address:	City/State/Zip:	
Phone: Home	Work:	Cell
Email Address:		
Parent/Guardian Birth Date:	Social Security #:	
Emergency Contact: Name:	Relationship	Phone:
Child/Client Name:		Gender: Male_____ Female_____
Birth Date:	Age:	
Brothers/Sisters Names and Ages		
Physician:		

II. Medical Information:

Medical Diagnosis (If any:_____

MEDICATIONS:_____

Does your child have any of the following	
___ Attention Deficit (Hyperactivity) Disorder	___ Cerebral Palsy _____
___ Autism	___ Prematurity _____
___ Asperger's Syndrome	___ Food allergies/special diet_____
___ Pervasive Developmental Disorder	___ Muscular weakness_____
___ Tourette's Syndrome	___ Seizures / Epilepsy_____
___ Learning Disabilities	___ Vision problems_____
___ Bipolar Disorder	___ Hearing problems_____
___ Anxiety	___ History of ear infections or tubes in ears (please circle)_____
___ Depression	___ Asthma_____
___ Posttraumatic Stress Disorder	___ Allergies (latex, medication)_____
___ Panic attacks	___ Stomach or intestinal problem:_____
___ Obsessive Compulsive Disorder	___ Casts or braces_____
___ Attachment Disorders	___ Surgery_____
___ Other mental health disorder	___ Serious injury_____
___Speech / Language disorders	___Hospitalization_____
	___ Other_____

Has child had vision test? Yes/No Results? _____ Has child had hearing test? Yes/No Results?_____

Has child been seen by occupational therapy in the past? If so, when, where and for what reason:_____

_____

_____

Please list and *include reports* from other evaluations or treatments your child has received (psychologist, PT, neurologist, OT, etc.)

Type Professional's Name Date

_____

_____

_____

_____

_____

III. Birth History

1. At birth, was there: induction ___Yes ___ No forceps/suction/vacuum used? ___Yes ___No

C-section? ___Yes ___No Was the C-section planned? ___Yes ___No

2. Was the child full term or premature at birth (how many months old)?_____

3. At birth, were there any complications such as:

Breech ___Yes ___No Difficulty breathing ___Yes ___No

Fractures ___Yes ___No Jaundice ___Yes ___No

Cord around neck ___Yes ___No Difficulty nursing ___Yes ___No

Hospitalized or intensive care after birth ____Yes ___No if so, how long?_____

Other issues with pregnancy or birth or hospitalization:_____

_____

4. Was your child adopted or in foster care? ___Yes ___No Child's age at adoption or when entered your care _____

If yes, adoption was: ____Domestic _____International: what country_____

Please identify any important details of adoption or foster care, adjustment to new home, particular challenges, etc.

_____

_____

_____

IV. Childhood and Developmental History

1. Did child crawl? ___Yes ___No If yes, did child crawl with knees off the floor? ___Yes ___No

If yes, was crawling phase brief? ___Yes ___No Did child drag a leg? ___Yes ___No

Did child scoot instead of crawl? ___Yes ___No Did child slide? ___Yes ___No

2. Is child toilet trained in: bowel ___ Yes ___No bladder ___Yes ___No Is child fearful of sitting on toilet? __Yes ___No

Are there accidents? ___Yes ___No How often_____ Does child have constipation? ___Yes ___No

3. Please give approximate ages when milestones were met, or comment on anything unusual

Roll over_____ Crawl_____ Chew solid food_____ Say words_____

Sit alone_____ Walk_____ Drink from cup_____ Say sentences_____

4. Is it difficult for the child to calm/soothe self? How does child calm/soothe self? _____

_____

5. **V. School:**

1. School attending:_____ Grade in school:_____

2. If in school, are there difficulties at school with any of the following?

____Reading	____Math	____Spelling	____Social skills	___Test taking
____Handwriting	____Organizing work	____Remembering information	____Restlessness	___ Anxiety
____Finishing tasks	____Attention	____ Following directions	____Peer relationships	___ Homework

3. If younger, are there any difficulties learning colors, letters, numbers, coloring, cutting, using material with hands, sitting in circle time, peer relationships, and/or beginning reading work (as appropriate for age of child)? Please circle. _____

_____

_____

_____

4. What are the specific problems in school?_____

_____

_____

_____

_____

5. Does child receive special services, have Individual Education Plan (IEP), ISP, or 504 plan? (please circle) ___Yes ___No

If yes, please describe:_____

_____

VI: General:

What are your concerns with your child's function? _____

_____

_____

_____

_____

_____

_____

What are your goals and priorities for treatment? What are your child's goals / what does he/she want to be able to do?_____

_____

_____

_____

_____

_____

_____

_____

_____

What are your child's gifts? What is he/she good at? What motivates your child?_____

_____

_____

_____

_____

VII. Sensory Processing Checklist:

Please check off the answer that most fits the child's responses and make comments if you would like. Some questions may not apply

SENSORY SENSITIVITY: Does/Is child:	Often	Some-times	Rarely/ Never	Comments
1. dislike or feel bothered by: Baths/showers, hair brushing/combing, haircutting, shampooing, or drying hair, nail cutting, brushing or flossing teeth, washing face, using hand sanitizer, hands in messy things, bumps on bed sheets, band-aids **Please mark all that apply.**				
2. dislike or feel bothered by clothing: Wet clothes, clothing waistbands, tight clothing, loose clothing, clothing tags, clothing seam either straight or crooked, socks, certain clothing fabric, socks, shoes, sandals, jeans. **Please mark all that apply**,				
3. dislike or feel bothered by touch to the body: having arms or back stroked, hugs, holding hands? **Please mark all that apply**				
4. dislike going barefoot on grass, sand, carpet, or dirty floor?				
5. prefer to touch rather than be touched?				
6. become angry/annoyed when bumped or pushed unexpectedly?				
7. tend to be more sensitive to pain than others?				
8. blink at bright lights or feel irritated by them?				
9. bothered by smells in the environment. Please list:_____ _____ _____				
10. bothered or distracted by sounds: toilet flushing, public hand dryers, door slamming, baby crying, dog barking, telephone ringing, sirens/alarms, lawnmowers, nail filing, blender, vacuum, hair dryer, hair dryer, coffee grinder, fireworks **Please mark all that apply**.				
11. bothered or distracted by background sounds: whispering, chewing, radio/TV, refrigerator, fluorescent lights buzzing, talking, clock ticking, fans, water dripping, utensils against each other (spoon in bowl) **Please mark all that apply**				
12. bothered by sounds in certain places: crowds, concerts, movies, malls, restaurants, cafeterias, gymnasiums, parties, sporting events, parties **Please mark all that apply**				
13. seem overloaded by environmental stimulation?				
14. seem to be on sensory overload frequently?				

BODY AWARENESS: Does (or is) child:	Often	Some-times	Rarely/ Never	Comments
1. have difficulty finding objects in pockets/ backpack without looking?				
2. have difficulty noticing food on face or messy hands?				
3. have a high tolerance to pain / not feel pain as much as others / engage in activities that would typically be painful to others?				
4. bang head, bite or pinch self? **Please mark all that apply**				
5. seem oblivious of bruises and heavy falls?				
6. chew or bite nails, or grind teeth?				
7. chew or lick on non-food items?				
8. bump into objects or people frequently?				
9. over or under-estimate the amount of force needed for a task?				
10. tend to spill, drop, or break things?				
11. play or interact with others roughly (hug too hard, head butt, slam into others, rough “high five”, etc.)				
12. seem clumsy or accident-prone?				
13. seek excessive touch input (touching people or objects, rubbing surfaces or textures, etc.)				
BALANCE / MOVEMENT PROCESSING: Does (or is) child:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. get uncomfortable or vomit from movement activities (merry-go-rounds, swings, car rides)?				
2. have difficulty walking on stairs or going down stairs?				
3. have difficulty with sudden starts or stops in the car or riding in car?				
4. have difficulty on escalators or elevators?				
5. have difficulty in the car on roundabouts (circular intersections)?				
6. avoid activities where head is upside down?				
7. dislike going on swings?				
8. avoid fast carnival rides that spin or go up and down?				
9. avoid roller coasters?				
10. fear heights or seem fearful if feet are off the floor?				
11. fearful of riding a bicycle?				
12. have difficulties with balance?				
13. walk on toes?				
14. move in and out of the chair, have difficulty sitting in chair, or fidget?				
15. wrap legs around chair legs, sit cross-legged in chair, place foot in chair, tip chair forward, etc.? **Please mark all that apply**				
16. in constant motion, rocking, running about, etc. **Please mark all that apply**				
17. seek excessive movement?				
18. jump a lot?				
19. seem to deliberately fall or tumble?				
20. like to spin self around?				
21. not seem to become dizzy?				

BALANCE / MOVEMENT PROCESSING: Does (or is) child:	Often	Some-times	Rarely/ Never	Comments
22. rock in seat or bed?				
23. seek activities where head is upside down ?				
24. shake head side to side or up and down?				
25. a "daredevil" or unaware of safety concerns with movement?				
26. lean on objects or others?				
MOTOR SKILLS: Does (or is) child:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. seem reluctant to participate in sports/games?				
2. have difficulty learning new motor activities (dance steps, sports)?				
3. have difficulty following the steps when putting something together?				
4. approach new motor activities cautiously?				
5. have difficulty performing tasks in sequence?				
6. have difficulty with motor tasks that have several steps?				
7. plays the same activities over and over				
8. have difficulty pumping self on swing?				
9. have difficulty swimming using the crawl or other strokes?				
10. have difficulty following two or three verbal directions given at once?				
11. misunderstand the meaning of “up”, “behind”, “on your back”, etc.?				
12. have speech or articulation difficulties?				
13. have difficulty learning to ride tricycle?				
14. have trouble learning to ride a bicycle?				
15. have difficulty catching balls?				
16. tend to be slow in dressing?				
17. tend to be slow with eating?				

FINE MOTOR SKILLS: Does (or is) child:	Often	Some-times	Rarely/ Never	Comments
1. have poor or awkward pencil grasp?				
2. experience fatigue in hand with writing?				
3. have difficulty with handwriting or legibility?				
4. avoid /have difficulty drawing or coloring?				
5. avoid/have difficulty cutting with scissors?				
6. have difficulty performing fine motor tasks such as manipulating objects in the hand, opening bottles, etc?				
7. have difficulty handling eating utensils: knife, fork? (**Please mark all that apply**				
8. have difficulty cutting or spreading with a knife? **Please mark all that apply**				
9. have trouble with buttons or zippers? **Please mark all that**				
10. have difficulty tying shoe laces?				

VISUAL PROCESSING: Does (or is) child:	Often	Some-times	Rarely/ Never	Comments
1. have difficulty/slow learning colors, shapes, or sizes?				
2. have difficulty/slow to learn letters or numbers?				
3. have difficulty or slow to learn reading?				
4. complain of headaches when reading?				
5. close one eye or tilt head when reading or looking at books?				
6. skip letter, words, or lines of text when reading?				
7. draw some numbers and letters backwards?				
8. have difficulty copying from the board to paper?				
9. mistake words with similar beginnings?				
10. have trouble finding an object in a busy background?				
11. have trouble following objects with eyes?				
12. become easily distracted by visual stimulation?				
13. avoid or have difficulty with eye contact?				
TASTE AND EATING: Does (or is) child	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. a “picky eater”?				
2. have difficulty with foods having textures: slimy, smooth, soft, lump, or meats? **Please mark all that apply**				
3. have difficulty eating smooth foods with a few lumps (e.g., soup, mashed potatoes)?				
4. have difficulty with foods mixed together (casseroles, soups, etc.)?				
5. have difficulty with chewy or crunchy foods?				
6. have difficulty eating new or unfamiliar foods?				
7. gag or choke with certain food? **Please mark all that apply**				
GENERAL / EMOTIONAL / SOCIAL: Does (or is) child:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. have strong outbursts of anger or emotions? When do they occur: (please circle if applies): after school, with peers, in certain places, unpredictable, other_____				
2. have difficulty calming self when upset ?				
3. tend to startle easily?				
4. have difficulty engaging in group activities?				
5. have difficulty with social skills?				
6. difficulty with changes in routines or transitions? (please circle)				
7. have difficulty falling asleep, remaining asleep, frequent waking, nightmares: **Please mark all that apply**				

VII. Primary Movement Patterns:

Please mark any items below that fit with your child.

Hands Supporting

_____ Frequent injuries with falls (doesn't put hand out to protect face)
_____ Lack of body and space awareness/boundaries
_____ Poor social boundaries (aggressive, standoffish, isolated, easily becoming a victim, bully or being bullied)

Babkin

_____ Tongue out of mouth or mouth movements when using hands
_____ Biting clothing or objects
_____ Nail biting

Babinski

_____ Difficulties with fine motor coordination
_____ Difficulties with gross motor coordination
_____ Poor balance
_____ Poor running or skipping
_____ Trips easily, clumsiness
_____ Walks on inside of feet
_____ Walks on outside of feet
_____ Walks on toes
_____ Walks with toes inward
_____ Walks with toes outward

Foot Tendon Guard

_____ Difficulty standing
_____ Improper crawling
_____ Poor coordination for climbing
_____ Poor coordination for jumping
_____ Poor coordination for running
_____ Poor grounding and stability
_____ Poor walking pattern

Leg Cross Flexion Extension

_____ Difficulty balancing on each foot
_____ Difficulty coordinating legs to ride a bicycle
_____ Hesitant when going down or climbing stairs
_____ Poor coordination across the middle of body
_____ Postural problems

Moro

_____ Becomes overly excited after movement activities
_____ Breath holding with effort
_____ Fearful of feet leaving ground
_____ Hypersensitivity to movement (i.e. does not like head tipped backwards)
_____ Motion sickness
_____ Poor balance, motion sickness
_____ Shallow breath patterns
_____ Seeks intense movement frequently

Fear Paralysis

_____ Difficulty completing tasks with sounds nearby
_____ Overly sensitive to loud noises
_____ Excessive reaction to touch
_____ Hears sounds others do not hear
____ Hypervigilant
_____ Hypersensitivity to sounds
_____ Hypersensitivity to touch
_____ Hypersensitivity to visual information
_____ Visually distracted

Symmetrical Tonic Neck Reflex

_____ Bumps into objects/people frequently
_____ Can't move hands, arms, head separately
_____ Difficulty visually tracking objects
_____ Discomfort and fatigue sitting with arms/legs bent or standing with arms/legs straight
_____ Difficulty sitting in chair for period of time; sitting on feet, feet wrapped around chair legs, etc.
_____ Keeps eyes too close to paper
_____ Moves as one unit
_____ Prefers sedentary play
_____ Problems with athletics
_____ Avoids new physical challenges
_____ Puts head down when drawing, reading, writing

Spinal Galant

_____ Discomfort with tight fitting clothing or clothing waistbands
_____ Bladder accidents
_____ Hyperactivity
_____ Poor gross motor coordination
_____ Tends to adjust body/fidget frequently when sitting in a chair
_____ Falls off chair

Spinal Perez

_____ Sound hypersensitivity
_____ Bed wetting
_____ Delayed crawling and walking, difficulty with walking pattern
_____ Difficulty with potty training/bed wetting
_____ Has difficulty controlling movements (too fast/slow, too hard/soft)
_____ Leans on people/objects for stability
_____ Plays roughly with people/objects
_____ Touch hypersensitivity

Asymmetrical Tonic Neck Reflex

_____ Difficulty following verbal directions
_____ Difficulty sequencing events
_____ Difficulty with attention, focus, memory
_____ Does not consistently respond to his/her name
_____ Frequently asks for repetition of directions/verbal Information
_____ Letter/number/word reversals
_____ Lack of hand dominance
_____ Says "what?" or asks for repetition
_____ Difficulty turning, rotating or twisting the body
_____ Difficulty with handwriting
_____ Difficulty throwing and catching
_____ Sound sensitivity